TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
ELITE HEALTHCARE FORT WORTH

Respondent Name
ARCH INSURANCE CO

MFDR Tracking Number
M4-13-3400

Carrier's Austin Representative
Box Number 19

MFDR Date Received
AUGUST 23, 2013

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "I have tried to get these claims paid without any success. This patient won their BRC hearing and all claims are to be paid in full. Patient has authorization for physical therapy. Office visits are recommended as determined to be medically necessary. Medical necessity for office visit is in conjunction with work status form 73."

Amount in Dispute: $836.78

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The carrier asserts that it has paid according to applicable fee guidelines and challenges whether the disputed charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 6, 2011 April 13, 2011	CPT Code 99213-25 Office Visit	$109.95/ea	$0.00
April 6, 2011 April 13, 2011	CPT Code 97140-GP (X2) Physical Therapy Services	$0.28/ea	$0.00
April 6, 2011 April 13, 2011	CPT Code 97112-GP (X2) Physical Therapy Services	$0.28/ea	$0.00
April 6, 2011 April 13, 2011	CPT Code 97110 (X4) Physical Therapy Services	$0.56	$0.00
April 18, 2011	CPT Code 99213-25 Office Visit	$0.34	$0.00
April 18, 2011	CPT Code 97140-GP (X2) Physical Therapy Services	$88.94	$0.00
April 18, 2011	CPT Code 97112-GP (X2) Physical Therapy Services	$98.62	$0.00

April 18, 2011	CPT Code 97110-GP (X4) Physical Therapy Services	$188.68	$0.00
January 11, 2012	CPT Code 99213-25 Office Visit	$111.47	$0.00
March 16, 2012	CPT Code 99213-25 Office Visit	$111.59	$0.00
March 16, 2012	CPT Code 99080-73 Work Status Report	$15.00	$0.00
TOTAL		$836.78	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.305 sets out the general Medical Dispute Resolution guidelines.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §133.308 sets out the procedure for Medical Dispute Resolution of Medical Necessity Disputes.
4. 28 Texas Administrative Code §134.600 requires preauthorization for physical therapy services.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 216 – Based on the findings of a review organization
   - 219 – Based on extent on injury
   - W1-Workers compensation state fee schedule adjustment.
   - 15, 150-Payer deems the information submitted does not support this level of service.
   - 29-The time limit for filing has expired.
   - 19, 197-Precertification/authorization/notification absent.

Issues

1. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of medical necessity?
2. Did the medical fee dispute referenced above contain information/documentation that indicates that there are **unresolved** issues of Extent of Injury?
3. Does a timely filing issue exist in this dispute?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement for services rendered on March 16, 2012 based upon reason code "216."

   Resolution of a Medical Necessity Dispute. The Division hereby notifies the requestor the appropriate process for resolution of an unresolved issue of medical necessity requires filing for an independent review to be conducted by an IRO (independent review organization) appropriately licensed by the Texas Department of Insurance, pursuant to 28 Texas Administrative Code §133.308. Information applicable to HEALTH CARE PROVIDERS on how to file for an IRO may be found at http://www.tdi.texas.gov/hmo/iro_requests.html under ***Health Care Providers or their authorized representatives.***

   Notice of Dispute Sequence. 28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding…medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding…medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021.

The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code §133.307. 28 Texas Administrative Code §133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals.

The division finds that due to the unresolved medical necessity issue, the medical fee dispute request for date of service March 16, 2012 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §133.308.

2. According to the explanation of benefits, the respondent denied reimbursement for services rendered on January 11, 2012 based upon reason code "219."

   Unresolved extent-of-injury dispute: The medical fee dispute referenced above contains unresolved issues of extent-of-injury for the same service(s) for which there is a medical fee dispute. The insurance carrier notified the requestor of such issues in its explanation of benefits (EOB) response(s) during the medical billing process.

   Dispute resolution sequence: 28 Texas Administrative Code §133.305(b) requires that extent-of-injury disputes be resolved prior to the submission of a medical fee dispute for the same services. 28 Texas Administrative Code §133.307(f) (3) (C) provides for dismissal of a medical fee dispute if the request for the medical fee dispute contains an unresolved extent of injury dispute for the claim. 28 Texas Administrative Code § 133.307(c) (2) (K) provides that a request for a medical fee dispute must contain a copy of each EOB related to the dispute.

   Extent-of-injury dispute process: The Division hereby notifies the requestor that the appropriate process to resolve the issue(s) of CEL, including disputes or disagreements among the parties over whether the medical services in dispute were related to the compensable injury, may be found in Chapter 410 of the Texas Labor Code, and 28 Texas Administrative Code §141.1. As a courtesy to the requestor, instructions on how to file for resolution of the extent of injury issue are attached.

   The division finds that due to the unresolved extent of injury issues, the medical fee dispute request for date of service January 11, 2012 is not eligible for review until a final decision has been issued in accordance with 28 Texas Administrative Code §141.1.

   Dismissal provisions: 28 Texas Administrative Code § 133.307(f) (3) provides that a dismissal is not a final decision by the Texas Department of Insurance, Division of Workers' Compensation ("Division"). The medical fee dispute may be submitted for review as a new dispute that is subject to the requirements of 28 Texas Administrative Code § 133.307. 28 Texas Administrative Code § 133.307 (c)(1)(B) provides that a request for medical fee dispute resolution may be filed not later than 60 days after a requestor has received the final decision, inclusive of all appeals, on the extent-of-injury dispute.

3. Dates of service April 6, 13, and 18, 2011, were denied based upon reason code "29."

   28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file the request with the division's MFDR Section or waive the right to MFDR. The division shall deem a request to be filed on the date the MFDR Section receives the request. A decision by the MFDR Section that a request was not timely filed is not a dismissal and may be appealed pursuant to subsection (g) of this section. (A) A request for MFDR that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The date of the services in dispute are April 6, 13, and 18, 2011. The request for medical dispute resolution was received in the Medical Fee Dispute Resolution (MFDR) section on August 23, 2013. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services do not involve issues identified in §133.307(c)(1)(B). The Division concludes that the requestor has failed to timely file this dispute with the Division's MFDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

   The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute, as addressed in 28 Texas Administrative Code §133.307(c)(1) and (c)(1)(A). For that reason, the merits of the issues raised by the parties to this dispute have not been addressed.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		11/19/2015
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.